Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# WAYNE COUNTY COMMUNITY COLLE
# 61298663
# 0070119080004 - 05X4G
# Effective Date: 01/01/2017

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

**Preauthorization for Select Services** - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

**Note:** A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

**Preauthorization for Specialty Pharmaceuticals** - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

## Eligibility Information

| Members | Eligibility Criteria |
|---|---|
| **Dependents** | • Subscriber's legal spouse<br>• **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26 |
| **Sponsored dependents** | • Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage. |

## Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Deductible** | $100 for one member,<br>$200 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office. | $250 for one member,<br>$500 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note:** Out-of-network deductible amounts also count toward the in-network deductible. |
| **Flat-dollar copays** | • $30 copay for office visits and office consultations<br>• $30 copay for online visits<br>• $30 copay for chiropractic and osteopathic manipulative therapy<br>• $250 copay for emergency room visits<br>• $30 copay for urgent care visits | • $250 copay for emergency room visits |
| **Coinsurance amounts (percent copays)**<br><br>**Note:** Coinsurance amounts apply once the deductible has been met. | • 50% of approved amount for private duty nursing care<br>• 10% of approved amount for mental health care and substance use disorder treatment<br>• 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) | • 50% of approved amount for private duty nursing care<br>• 30% of approved amount for mental health care and substance use disorder treatment<br>• 30% of approved amount for most other covered services |
| **Annual coinsurance maximums** - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts | $500 for one member,<br>$1,000 for the family (when two or more members are covered under your contract) each calendar year | $1,500 for one member,<br>$3,000 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum. |

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Annual out-of-pocket maximums** - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable | $6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year | $12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum. |
| **Lifetime dollar maximum** | None | |

## Preventive care services

| Benefits | In-network | Out-of-network |
|---|---|---|
| Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br>**Note:** Additional well-women visits may be allowed based on medical necessity | Not covered |
| Gynecological exam | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br>**Note:** Additional well-women visits may be allowed based on medical necessity. | Not covered |
| Pap smear screening - laboratory and pathology services | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |
| Voluntary sterilization for females | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician | 100% (no deductible or copay/coinsurance) | 100% after out-of-network deductible |
| Contraceptive injections | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Well-baby and child care visits | 100% (no deductible or copay/coinsurance)<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit | Not covered |
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act | 100% (no deductible or copay/coinsurance) | Not covered |
| Fecal occult blood screening | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |
| Flexible sigmoidoscopy exam | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |

| Benefits | In-network | Out-of-network |
|---|---|---|
| Prostate specific antigen (PSA) screening | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |
| Routine mammogram and related reading | 100% (no deductible or copay/coinsurance)<br><br>**Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. | 70% after out-of-network deductible<br><br>**Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. |
| | One per member per calendar year | |
| Colonoscopy - routine or medically necessary | 100% (no deductible or copay/coinsurance) for the first billed colonoscopy<br><br>**Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. | 70% after out-of-network deductible |
| | One per member per calendar year | |

## Physician office services

| Benefits | In-network | Out-of-network |
|---|---|---|
| Office visits - must be medically necessary | $30 copay per office visit | 70% after out-of-network deductible |
| Online visits - by physician must be medically necessary<br><br>**Note:** Online visits by a vendor are not covered. | $30 copay per online visit | 70% after out-of-network deductible |
| Outpatient and home medical care visits - must be medically necessary | 90% after in-network deductible | 70% after out-of-network deductible |
| Office consultations - must be medically necessary | $30 copay per office consultation | 70% after out-of-network deductible |
| Urgent care visits - must be medically necessary | $30 copay per urgent care visit | 70% after out-of-network deductible |

## Emergency medical care

| Benefits | In-network | Out-of-network |
|---|---|---|
| Hospital emergency room | $250 copay per visit (copay waived if admitted or for an accidental injury) | $250 copay per visit (copay waived if admitted or for an accidental injury) |
| Ambulance services - must be medically necessary | 90% after in-network deductible | 90% after in-network deductible |

## Diagnostic services

| Benefits | In-network | Out-of-network |
|---|---|---|
| Laboratory and pathology services | 90% after in-network deductible | 70% after out-of-network deductible |
| Diagnostic tests and x-rays | 90% after in-network deductible | 70% after out-of-network deductible |
| Therapeutic radiology | 90% after in-network deductible | 70% after out-of-network deductible |

## Maternity services provided by a physician or certified nurse midwife

| Benefits | In-network | Out-of-network |
|---|---|---|
| Prenatal care visits | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Postnatal care visit | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Delivery and nursery care | 90% after in-network deductible | 70% after out-of-network deductible |

## Hospital care

| Benefits | In-network | Out-of-network |
|---|---|---|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies<br><br>**Note:** Nonemergency services must be rendered in a **participating** hospital. | 90% after in-network deductible | 70% after out-of-network deductible |
| | Unlimited days | |
| Inpatient consultations | 90% after in-network deductible | 70% after out-of-network deductible |
| Chemotherapy | 90% after in-network deductible | 70% after out-of-network deductible |

## Alternatives to hospital care

| Benefits | In-network | Out-of-network |
|---|---|---|
| Skilled nursing care - must be in a **participating** skilled nursing facility | 90% after in-network deductible | 90% after in-network deductible |
| | Limited to a maximum of 120 days per member per calendar year. | |
| Hospice care | 100% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) |
| | Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management) | |
| Home health care:<br>• must be medically necessary<br>• must be provided by a **participating** home health care agency | 90% after in-network deductible | 90% after in-network deductible |
| Infusion therapy:<br>• must be medically necessary<br>• must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC)<br>• may use drugs that require preauthorization - consult with your doctor | 90% after in-network deductible | 90% after in-network deductible |

## Surgical services

| Benefits | In-network | Out-of-network |
|---|---|---|
| Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility | 90% after in-network deductible | 70% after out-of-network deductible |
| Presurgical consultations | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Voluntary sterilization for males<br><br>**Note:** For voluntary sterilizations for females, see "**Preventive care services.**" | 90% after in-network deductible | 70% after out-of-network deductible |
| Voluntary abortions | 90% after in-network deductible | 70% after out-of-network deductible |

## Human organ transplants

| Benefits | In-network | Out-of-network |
|---|---|---|
| Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 100% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) - in designated facilities **only** |
| Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 90% after in-network deductible | 70% after out-of-network deductible |
| Specified oncology clinical trials<br><br>**Note:** BCBSM covers clinical trials in compliance with PPACA. | 90% after in-network deductible | 70% after out-of-network deductible |
| Kidney, cornea and skin transplants | 90% after in-network deductible | 70% after out-of-network deductible |

## Mental health care and substance use disorder treatment

**Note:** Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Inpatient** mental health care and **inpatient** substance use disorder treatment | 90% after in-network deductible | 70% after out-of-network deductible |
| | Unlimited days | |
| Residential psychiatric treatment facility:<br>• covered mental health services **must** be performed in a residential psychiatric treatment facility<br>• treatment **must** be preauthorized<br>• subject to medical criteria | 90% after in-network deductible | 70% after out-of-network deductible |
| Outpatient mental health care:<br>• Facility and clinic | 90% after in-network deductible | 90% after in-network deductible in participating facilities **only** |
| • Physician's office | 90% after in-network deductible | 70% after out-of-network deductible |
| Outpatient substance use disorder treatment - in approved facilities **only** | 90% after in-network deductible | 70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network) |

## Autism spectrum disorders, diagnoses and treatment

| Benefits | In-network | Out-of-network |
|---|---|---|
| Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization<br><br>**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. | Not covered | Not covered |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder | Not covered | Not covered |
| Other covered services, including mental health services, for autism spectrum disorder | Not covered | Not covered |

## Other covered services

| Benefits | In-network | Out-of-network |
|---|---|---|
| Outpatient Diabetes Management Program (ODMP)<br><br>**Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.<br><br>**Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs. | • 90% after in-network deductible for diabetes medical supplies<br>• 100% (no deductible or copay/coinsurance) for diabetes self-management training | 70% after out-of-network deductible |
| Allergy testing and therapy | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Chiropractic spinal manipulation and osteopathic manipulative therapy | $30 copay per visit | 70% after out-of-network deductible |
| | Limited to a **combined** 24-visit maximum per member per calendar year | |
| Outpatient physical, speech and occupational therapy - provided for rehabilitation | 90% after in-network deductible | 70% after out-of-network deductible<br><br>**Note:** Services at nonparticipating outpatient physical therapy facilities are not covered. |
| | Limited to a **combined** 60-visit maximum per member per calendar year | |
| Durable medical equipment<br><br>**Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM. | 90% after in-network deductible | 90% after in-network deductible |
| Prosthetic and orthotic appliances | 90% after in-network deductible | 90% after in-network deductible |
| Private duty nursing care | 50% after in-network deductible | 50% after in-network deductible |

## BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

## Member's responsibility (copays and coinsurance amounts)

**Note:** Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

| Benefits | | 90-day retail network pharmacy | * In-network mail order provider | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|---|---|---|---|---|---|
| Tier 1 - Generic or select prescribed over-the-counter drugs | 1 to 30-day period | You pay $10 copay | You pay $10 copay | You pay $10 copay | You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay $20 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $20 copay | You pay $20 copay | No coverage | No coverage |
| Tier 2 - Preferred brand-name drugs | 1 to 30-day period | You pay $40 copay | You pay $40 copay | You pay $40 copay | You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay $80 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $80 copay | You pay $80 copay | No coverage | No coverage |
| Tier 3 - Nonpreferred brand-name drugs | 1 to 30-day period | You pay $80 copay | You pay $80 copay | You pay $80 copay | You pay $80 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay $160 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $160 copay | You pay $160 copay | No coverage | No coverage |

**Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

## Covered services

| Benefits | 90-day retail network pharmacy | * In-network mail order provider | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|---|---|---|---|---|
| FDA-approved drugs | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| Prescribed over-the-counter drugs - when covered by BCBSM | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| State-controlled drugs | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA | 100% of approved amount | 100% of approved amount | 100% of approved amount | 75% of approved amount |
| Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act | 100% of approved amount | Not covered | 100% of approved amount | 75% of approved amount |
| FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered) | 100% of approved amount | 100% of approved amount | 100% of approved amount | 75% of approved amount |
| Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered) | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs<br><br>**Note:** Needles and syringes have no copay/ coinsurance. | 100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug | 100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug | 100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug | 75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug |

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

## Features of your prescription drug plan

| | |
|---|---|
| Custom Drug List | A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.<br>• **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.<br>• **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.<br>• **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs. |
| Prior authorization/step therapy | A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**. |
| Drug interchange and generic copay/ coinsurance waiver | BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.<br><br>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver. |
| Mandatory maximum allowable cost drugs | If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum. |
| Quantity limits | To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. |